INTERFACILITY TRANSPORT TASK FORCE MINUTES

October 30, 2001
Double Tree Hotel
Ontario, California

Attendees: Cliff Larrabee, David Nevins, James Ridenour, Loren Johnson, MD, Lou Meyer, Ray Ramirez, Kathy Montoya, Edward Ballerini, RN, Bob Eisenman, PhD, Scott Wallace, Liz Raganold, RN

Note: Membership information has been updated and attached.

EMSA Staff: Bonnie Sinz, RN

Approval of Minutes

Action items: Minutes were approved as written

Approval of Agenda

Action items: Agenda approved as distributed.

Ad Hoc Group 1 Minutes (refer to attachment)

Task Force discussion on Group 1 report:

- There is a supply/demand mismatch for Critical Care Transport resources
- ALS/modified ALS could respond to the demand
- Some LEMSAs prohibit ALS IFT; group believes this is to protect the integrity of the 9-1-1 system
- Bonnie will send out a survey to all LEMSAs asking for information on IFT practices at CCT, ALS and gurney car levels
- Group 3 will work on guidelines for expanded scope ALS for IFT purposes
- There are opportunities for improving ALS level IFT while protecting the 9-1-1 system
- Gurney cars are non-regulated except rules for MediCal reimbursement
- Some gurney car companies employ EMT-Is without any LEMSA oversight
- There is a need for low level transport mechanism

Ad Hoc Group 3 Minutes

Task Force Discussion on Group 3 Report:

- There is a need for transferring MDs to be educated on the capabilities of each level of IFT
- A compilation of minimum education/training standards for transport team staff was distributed
- Each standard will have a reference attached
- Standards will reflect current industry standards and be designed to be attainable
- EMS Blueprint will be researched

System Standards and Guidelines

Discussion: Tabled until January meeting

Reimbursement Procedures

Discussion: Reimbursement is now available for IFT member travel expenses. See attached instructions and claim form.

Next Meeting Date/Location

Discussion: The Ad Hoc Groups will continue to work on their goals and objectives in separate meetings and/or conference calls organized by each group lead.

Action items: The next meeting is scheduled for **January 15, 2002 in the North**. The Ad Hoc Groups will meet from 10-12 noon with the Task Force meeting from 12-3 p.m. Each chairperson will coordinate Ad Hoc group meetings.

EMS Authority
Interfacility Transport Task Force
Group 1 Minutes
October 30, 2001

Bob Eisenman

Chair, Group 1

Group 1 Attendance:

Bob Eisenman, Chair (Managed Care)
Ed Ballerini (California Healthcare Association)
Loren Johnson, MD (California Emergency Medical Physicians)
Lou Meyer (EMS Commission)
Kathy Montoya (Centers for Medicare and Medicaid Services)
David Nevins (California Ambulance Association)
Ray Ramirez (Fire Chief's Association)
Bonnie Sinz (EMS Authority)

Group 1 discussed Interfacility Transports from the perspective of a SWOT – Strengths, Weaknesses, Opportunities and Threats – analysis. The discussion was wide ranging and included the likely affects of the new Medicare ambulance fee schedule when it is implemented. However the discussion focused primarily on problems associated with critical care transports (CCT) and the use of ALS interfacility transports. Group 1 also discussed the use of gurney cars (see discussion following that of CCT/ALS Interfacility Transports).

CCT and ALS Interfacility Transports

The discussion included the following points:

- The ability to move patients between one medical care facility and another is an integral part of medical care practice today and physicians, hospitals and other medical care providers predict that the use of interfacility transports will grow in the future.

- Presently hospital ED diversions and problem of assuring on-call physician specialist back up to ED's are increasing the need for interfacility transports. The potential impact of a terrorist event --- added to existing ED overcrowding --- could also significantly increase the use of interfacility transports.

- Presently there appears to be a mismatch between the need for and the available of interfacility transport resources.

- This resource gap is particularly apparent in the need to move critical care patients to higher levels of care and for special tests and procedures.

- In many communities Critical Care Transport (CCT) units have not been able to assure a timely response to pick up and transport a critical patient. This is a serious problem in that these are precisely the patients with the potential for the worst outcomes.

- The inability to assure timely CCT responses appears to be a function of a shortage of CCT units and a shortage of RN's to staff CCT units, relative to demand.

- However it was noted that many of the patients currently being transported by CCT units don't need CCT level of care and could safely, appropriately and more timely be transported by ALS units and paramedic level of service.

- Some committee members noted that in counties where ALS is used for interfacility transports, CCT resources are freed up for the most critical transports and timeliness and delays tend not to be a problem.

- ✍ It was also noted that local EMS Agencies (LEMSA) vary on their protocols and use of ALS for interfacility transports. The range is from some counties (LEMSA's) prohibiting the use of ALS for interfacility transport to others allowing for expanded training and scope of practice for ALS interfacility transports (e.g. recent examples are Alameda and Contra Costa Counties).

- ✍ Other barriers (in addition to prohibitions) to the increased use of ALS for interfacility transport include:

    - Some emergency department and other physicians, hospitals and other heath care professionals that order ambulances are not knowledgeable about the skills and scope of practice available in ALS/paramedic ambulances.

    - LEMSA concern that if an ambulance leaves the county it will deplete adequate ambulance resources within that county or at times, requirements for ambulances to stay within their counties/jurisdiction.

    - Exclusive ambulance contracts can inadvertently limit the availability of certain ambulance levels of resource to the community if they do not include or referenced all levels of ambulance resource or allow for alternative providers.

Recommendation I:

Based on its 10/20/01 discussion Group 1 recommends that the EMSA Interfacility Transport Task Force focus on the following:

Goal 1 - Increase the access to and availability of ALS for interfacility transports.

Specific action steps would include:

1. Survey LEMS Agencies to identify which counties prohibit or have barriers to the use of ALS for interfacility transports.

2. As appropriate provide consultation and support to resolving identified barriers to the use of ALS interfacility.

3. Develop education materials for hospitals, ED physicians, and others involved with interfacility transports on the skills and scope of practice available in the different levels (BLS, ALS, CCT and transport with a medical facility's MD, RN or specialty provider). Educational materials might include examples of medically appropriate transports at the various levels as well as blinded case examples.

4. Develop state standard guidelines for skill set, training and scope of practice for BLS, ALS and RN's involved in interfacility transports. Such guidelines to include existing and state-endorsed expanded scope for practice (especially for ALS).

5. Develop an evaluation tool to test the hypotheses that the use of ALS (i.e. both existing and expanded scope of practice) for interfacility transport reduces the need for and timeliness problems associated with current CCT interfacility transports. Develop recommendations for future action as necessary, based on the findings.

Gurney Cars

Group 1 also discussed Gurney Cars (gurney vans) and specifically, situations where some providers are using EMT's on gurney cars. It was noted that these EMT's are essentially unregulated and that potential patient care issues can result depending on the severity of the patient transported and the level of services provided in such vehicles.

It was also noted that while many ambulance providers also provide gurney car services and there are other small providers, fees are usually quite low and that payment typically comes from private users. Medicare and most (all?) health insurers do not cover gurney cars. The sole exception is Medi-Cal in certain situations.

On the other hand, Group 1 noted that gurney cars can be an appropriate and cost effective mode of transport for some patients and the issue has often been that gurney cars are not sufficiently available to ED's and other medical facilities.

Recommendation II:

Group 1 thought that another possible area of focus could be the establishment of appropriate guidelines for the medical appropriateness of the use of gurney cars for interfacility transport and the establishment of regulations for the skills, training, equipment and personnel used in such interfacility transports.

✍ IFT Task Force Membership

Revised 11/21/01

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